TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Ahmed Khalifa, M.D.

**Respondent Name**
Houston ISD

**MFDR Tracking Number**
M4-10-4683

**Carrier's Austin Representative**
Box Number 21

**MFDR Date Received**
July 8, 2010

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per DWC rule 134.202(e)(6)(C)(i)(II) the fee for assessment of M.M.I. date with modifier V5 is $187.02. Additionally per DWC rule 134.202(e)(6)(C)(iii)(II)(a) the fee for assessment of impairment rating based on Diagnosis Related Estimates is $150.00. Furthermore, based on DWC rule 134.202(e)(6)(C)(iii)(II)(b)(1) the fee for assessment of impairment rating for an extremity is $300.00. A total of $637.02. However, the carrier made a reimbursement of $374.04."

**Amount in Dispute:** $262.98

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The bill appears to be submitted with an incorrect reimbursement amount for the services provided."

**Response Submitted by:** Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 26, 2010 | Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating | $262.98 | $120.40 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - MUE01 – Denied – Exceeds maximum units of service considered reasonable and necessary.

- W1 – Workers compensation state fee schedule adjustment.

**Issues**

1. What are the applicable fee guidelines for the services in dispute?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The dispute involves procedure code 99455-V5, for date of service April 26, 2010. In their position statement, the requestor references "DWC rule 134.202." 28 Texas Administrative Code §134.204(a) states:

   (2) This section applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008.
   (3) For workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.

   Because the disputed services involve workers' compensation specific services for a date of service after March 1, 2008, the applicable fee guidelines for these services is 28 Texas Administrative Code §134.204.

2. Per 28 Texas Administrative Code §134.204(j)(3),

   The following applies for billing and reimbursement of an MMI evaluation.
   (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.
      (i) Reimbursement shall be the applicable established patient office visit level associated with the examination.
      (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.
   (B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:
      (i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection

   The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement and billed procedure code 99455 with modifier V5. Modifier V5 corresponds with the established patient office visit represented by procedure code 99215. Reimbursement for this code is determined in accordance with 28 Texas Administrative Code §134.203.

   28 Texas Administrative Code §134.203(c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2010 is $54.32.

   For procedure code 99215 on April 26, 2010, the relative value (RVU) for work of 2.11 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 2.110000. The practice expense (PE) RVU of 1.45 multiplied by the PE GPCI of 0.940 is 1.363000. The malpractice (MP) RVU of 0.10 multiplied by the MP GPCI

of 1.065 is 0.106500. The sum of 3.579500 is multiplied by the Division conversion factor of $54.32 for a MAR of $194.44.

Per 28 Texas Administrative Code §134.204(j)(4),

> The following applies for billing and reimbursement of an IR evaluation …
> (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
> (i) Musculoskeletal body areas are defined as follows:
> (I) spine and pelvis;
> (II) upper extremities and hands; and,
> (III) lower extremities (including feet).
> (ii) The MAR for musculoskeletal body areas shall be as follows…
> (II) If full physical evaluation, with range of motion, is performed:
> (-a-) $300 for the first musculoskeletal body area.
> (-b-) $150 for each additional musculoskeletal body area.

The submitted documentation supports that the requestor provided an impairment rating and performed a full physical evaluation with range of motion for the cervical spine. The requestor's position statement indicated that they are also seeking reimbursement for the second body area of an extremity. However, the submitted documentation does not support that an impairment rating was provided for another body area. Therefore, the correct MAR for this examination is $300.00.

3. The total MAR for the disputed services is $494.44. The insurance carrier paid $374.04. An additional reimbursement of $120.40 is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $120.40.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $120.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Laurie Garnes | February 10, 2016 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.